

Perinatal Hepatitis B Intake Form
Fax to 517-763-0470; or call 517-388-4815, 517-897-3236 or 517-242-8319

Mom's name _____ Date of birth _____ MDSS # _____
 Address _____ City _____ Zip _____ County _____
 Telephone # _____ Emergency contact name & # _____ Grav _____ Para _____
 Race: Asian/PI Black White Amer Indian Alaska Native Other _____ Unknown
 Ethnicity: Hispanic Non-Hispanic Unknown Method of Delivery Vaginal Cesarean
 Mom's Country of Birth _____ Interpreter Needed Y N If Yes, Language _____
 Mom's Insurance Private Medicaid Uninsured County Health Plan Medicare Military (Tricare) Unknown

(P = Positive/Reactive; N = Negative/Non-Reactive; NT = Not Tested; U = Unknown)											
HBsAg	____ / ____ / ____	P	N	NT	U	Repeat HBsAg	____ / ____ / ____	P	N	NT	U
Date HBsAg Reported ____ / ____ / ____ How Reported: Electronic Paper Lab OB Hospital Other _____											
HBeAg	____ / ____ / ____	P	N	NT	U	HBeAb	____ / ____ / ____	P	N	NT	U
Anti-HBc IgM	____ / ____ / ____	P	N	NT	U	Anti-HBc	____ / ____ / ____	P	N	NT	U
HBV DNA	____ / ____ / ____	P	N	NT	U	HBV Viral Load	_____ Unit Type _____				
Other Infections/Conditions (HCV, HIV, Syphilis, Other STIs, etc) _____											

Mom Being Monitored for HBV? Y N U Mom Being Treated for HBV? Y N U

If yes, please indicate: Start Date End Date Reported By
Treatment Type _____ **Mom History** **Med Record** **Other** _____
Treatment Type _____ **Mom History** **Med Record** **Other** _____

Physician Monitoring/Providing Treatment _____ Telephone # _____

Mom Get Tdap (*this pregnancy*) Y N Date ____ / ____ / ____ Flu (*this pregnancy*) Y N Date ____ / ____ / ____ Doses in MCIR Y N

Prenatal Care Provider (PCP) Information:			
PCP/Facility Name _____	EDC Date ____ / ____ / ____	Telephone # _____	
Address _____		City _____ Zip _____	
Hospital to Deliver _____		Reporting Information Sent to PCP Y N Date ____ / ____ / ____	

Household/Sexual Contact Information:

First/Last Name (relationship)	DOB	HBIG	Hep B #1	Hep B #2	Hep B #3	HBsAg, anti-HBs and/or anti-HBc Results	Test Date

Contact's Provider Name _____ Address _____
 City _____ Zip _____ Telephone # _____
 CD Nurse _____ Telephone # _____

DCH-1398 (Rev. 08/17/21) Michigan Department of Health & Human Services (MDHHS) AUTHORITY: PA 368 of 1978, as amended

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